Testimony of

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on

RURAL HOSPITALS

before the

SENATE APPROPRIATIONS SUBCOMMITTEE

ON AGRICULTURE, RURAL DEVELOPMENT, & RELATED AGENCIES

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Chairman Cochran, Senator Kohl, thank you for inviting me to be here today to discuss our efforts to support hospitals in America's rural areas. We understand that rural providers face unique challenges in serving the medical needs of their beneficiaries, and helping them is a high priority for us.

Rural hospitals tend to be smaller, have difficulty attracting and keeping health care professionals, and they are more dependent on Medicare patients. About one in four Medicare beneficiaries live in rural America, and rural providers serve a critical role in areas where the next nearest provider may be hours away. Yet many of these rural providers have higher average costs than their more urban counterparts and face difficulty maintaining enough patients to break even. As you know, Chairman Cochran, I have visited some of these facilities in Mississippi and other States to better understand their situation.

Medicare has made exceptions and special arrangements to address the needs of rural America and strengthen providers in these areas. The Balanced Budget Act included several provisions to help rural providers. The Balanced Budget Refinement Act provided further assistance, investing about $1 billion over 5 years to help rural providers.

Most recently, the President recognized the challenges rural hospitals face when he included $1 billion in additional funding over 10 years specifically for rural hospitals in his Midsession Review budget. This proposal would further assist rural facilities by increasing Medicare payment to all hospitals by $10 billion over 10 years.

In addition, we have taken administrative steps to help rural hospitals. And we have established a Rural Health Initiative within our agency to increase and coordinate attention to rural issues. This initiative includes senior staff and a specially designated rural point person in each of our 10 regional offices to respond to rural provider inquiries and concerns. And we are proceeding with demonstration projects to expand telemedicine services in Medicare.

We will continue to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. And we want to work with Congress to make any additional adjustments that may be necessary to ensure that rural providers can continue to provide beneficiaries with access to the high quality care they deserve.

Medicare-s Special Rural Designations

Medicare has long recognized the special needs of rural providers, and includes several special designations and enhanced payment systems for specific types of rural providers. These include:

- *Critical Access Hospitals:* These facilities have no more than 15 inpatient beds, offer 24 hour emergency care, and are located more than a 35 mile drive from any other hospital. They are reimbursed based on what they spend for each patient, rather than on the average expected cost for specific diagnoses that most hospitals are paid.
- *Sole Community Hospitals:* These facilities serve as the sole source of inpatient care in a community, either because they are geographically isolated, or because severe weather conditions or local topography prevents travel to another hospital. They can be paid higher rates based on their own previous costs.
- *Medicare Dependent Hospitals:* These facilities have fewer than 100 beds, do not serve as a Sole Community Hospital, and Medicare patients accounted for at least 60 percent of inpatient days or discharges during 1987. They also can be paid higher rates based on their own previous costs.
- *Rural Referral Centers:* These facilities have 275 or more beds, serve beneficiaries living more that 25 miles away or referred by other hospitals, or have specialist as more than half of staff physicians. They receive higher pay to assist in caring for low income patients and can more easily qualify for higher payments based on nearby urban wage rates.

Balanced Budget Act

The Balanced Budget Act of 1997 created the Critical Access Hospital program, and built upon other special provisions for rural providers. It:

- reinstated the Medicare Dependent Hospital designation, which had expired in 1994;
- permanently grandfathered rural referral centers;
- allowed more rural hospitals to obtain special disproportionate share hospital payments that are available to hospitals serving large numbers of low income patients; and
- authorized payment for telemedicine, in which medical consultations are conducted via phones and computers, for beneficiaries residing in rural areas that have a shortage of health care professionals.

The BBA also included payment reforms for several providers that directly impact rural hospitals. For example, it modified inpatient hospital payment rules. It also mandated development and implementation of prospective payment systems for skilled nursing facilities, home health agencies, outpatient hospital care, and rehabilitation hospitals to encourage facilities to provide care that is both efficient and appropriate.

Balanced Budget Refinement Act

Working together, Congress and the Administration last year enacted the Balanced Budget Refinement Act (BBRA), which further enhanced these special payments for rural providers. It included several provisions to assist Critical Access Hospitals, such as:

- applying the 96-hour length of stay limit on an average annual basis;
- permitting for-profit hospitals to qualify for Critical Access Hospital designation;

- removing constraints on length of stay in Aswing beds@ in hospitals with a total of 50 to 100 beds that serve both acute care and skilled nursing patients;
- allowing hospitals that closed or downsized since 1989 to be Critical Access Hospitals;
- permitting Critical Access Hospitals to streamline their billing processes by combining physician and hospital charges; and,
- eliminating beneficiary coinsurance for clinical laboratory tests furnished by a Critical Access Hospital.

For Sole Community Hospitals, the BBRA included a higher pay increase, fully adjusted for inflation, for FY 2001. And it extended the Medicare Dependent Hospital program for five years. For other rural hospitals, the BBRA holds them harmless for 4 years during the transition to the new prospective payment system for hospital outpatient care, and provides separate, budget-neutral payments for high-cost patients and certain drugs, devices, and biologicals for all hospitals, which will especially help hospitals that would otherwise have had to spread these costs across a small case load.

To promote physician services, the BBRA raised the cap on medical residents by 30 percent in rural areas. It also included incentives to encourage urban physician education programs to establish separate training programs in rural areas.

For skilled nursing facilities that are part of many rural hospitals, the BBRA provided an immediate increase in payment for high-cost patients. It created special payments to facilities that treat a high proportion of AIDS patients, and excluded certain expensive items and services from consolidated billing requirements, such as ambulance services for dialysis, prostheses, and chemotherapy. Importantly, the BBRA provided an across-the-board increase of 4 percent for FY 2001 and FY 2002 for skilled nursing facilities, and gave them options in how their rates are calculated. It also placed a two-year moratorium on physical and occupational therapy caps in the BBA, which appeared to be presenting particular problems for patients in these facilities.

For home health agencies that also are part of many rural hospitals, the BBRA delayed a scheduled 15 percent pay cut until after the first year the new home health prospective payment system is in place. It also provided an immediate adjustment to per beneficiary limits for certain agencies, gave extra pay to help cover the costs associated with the OASIS quality survey system, and excluded durable medical equipment from consolidated billing under the prospective payment system. Once the prospective payment system is in place, payments will be tailored specifically to the condition and needs of the patients and there will be no per visit or per beneficiary limits. A case-mix adjusted payment will be made for each 60-day episode of care, the limit on the number payment episodes will be removed, and agencies will receive extra pay for more costly cases.

President=s Midsession Budget

The President=s Midsession Budget proposal includes a reserve for specific provisions to help rural hospitals, which total $500 million over five years and $1 billion over 10 years. This money would be used for policies to improve the sustainability of rural hospitals, similar to those in the bipartisan AHealth Care Access and Rural Equality Act of 2000 (H-CARE)@, introduced by Senator Conrad and cosponsored by you, Chairman Cochran, Senator Harkin, and others in the Senate and House of Representatives. H-CARE, for example, would:

- provide payment increases that are fully adjusted for inflation to all rural hospitals with 100 beds

or less;

- make the Medicare Dependent Hospital program permanent and make it easier for hospitals to qualify by letting them use any of the three most recent audited cost reporting periods rather than their 1987 cost reporting period as mandated under current law;
- pay Critical Access Hospitals for clinical diagnostic services based on reasonable costs and without the beneficiary copayment;
- extend payment flexibilities for Sole Community Hospitals; and
- provide grants for upgrading data systems.

We also would consider improving equity for rural hospitals in the Medicare disproportionate share hospital (DSH) formula, which provides additional funding for facilities that serve large numbers of low income patients.

In addition, the Midsession Budget proposal would provide assistance for all hospitals totaling $10 billion over 10 years, as well as $2 billion over 10 years for skilled nursing facilities and $3 billion over 10 years for home health agencies. All of these provisions will result in increased payments to rural hospitals and other rural providers. Including the reserve for rural hospital policies, the proposal includes a reserve fund of $21 billion over 10 years for developing future policies.

Administrative Actions

We have taken a number of administrative steps to further assist rural providers. For example, we have made it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. This allows them to apply for all the special rural designations described above and the higher payments these designations confer.

We are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility=s outpatient rates that is used to calculate inpatient rates. We are postponing for two years expansion of the BBA Atransfer policy,@ which limits hospital payments when patients with certain diagnoses are discharged early to a post-acute care setting, and considering whether further postponement is warranted. We also are working with colleagues at the General Accounting Office and Medicare Payment Advisory Commission to review the impact and appropriateness of the wage index that is used to factor local health care wages into Medicare payment rates and generally results in lower payments to rural hospitals than to their urban counterparts.

For skilled nursing facilities, we are using our administrative flexibility to refine, in a budget neutral way, the manner in which we classify medical conditions for purposes of payment that more accurately reflects the full range of costs incurred on behalf of sicker patients. The refinements should increase payments for patients with complex medical conditions.

For home health agencies, we are providing financial relief by extending the time frame for repaying overpayments resulting from the interim payment system from one year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds until October 1, 2000. And we have eliminated a Asequential billing@ requirement that had been problematic for some agencies, including some in rural areas.

Rural Workgroup

In an effort to redouble our efforts to more clearly understand and actively address the special circumstances of rural providers and beneficiaries, we last year launched a new Rural Health Initiative. We are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration=s Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are providing services to rural beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. The work group is co-chaired by Linda Ruiz in our Seattle regional office and Tom Hoyer in our central office headquarters in Baltimore. Each of our ten regional offices now has a rural issues point person that you and your rural provider constituents can call directly to raise and discuss issues, ideas, and concerns. A list of these contacts and their respective States is attached to my testimony. We are confident that this initiative will ensure that Medicare policies are attuned to the needs of rural health providers and beneficiaries.

Telemedicine

We are proceeding with projects to evaluate Medicare coverage for telemedicine. We recently completed a comprehensive, $230,000 technology assessment of telemedicine, in conjunction with the Agency for Healthcare Research and Quality, under contract with the Oregon Health Sciences University. This study involved an assessment of the clinical and scientific literature dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of Astore and forward@ technologies, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services. We will examine the results of this study to determine if there is a need to expand telemedicine beyond the current payment regulations.

We are also testing expanded coverage for telemedicine. On February 28, 2000, we awarded a $28 million cooperative agreement to Columbia University for the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore how teleconsultations between physicians in New York City and rural, upstate New York affect diabetic patient care and program costs.

Conclusion

We are all committed to ensuring rural beneficiaries' continued access to quality care, and we are all concerned about the disproportionate impact that policy changes can have on rural health care providers. The Balanced Budget Act, the Balanced Budget Refinement Act, and the administrative actions we have taken address these concerns with specific provisions targeted to assist rural providers. Our Rural Health

Initiative and our consultation with the SBA will help us to take any additional steps that may be appropriate.

We are very grateful for this opportunity to discuss our efforts to help rural providers and beneficiaries, and to explore further actions we might take to address their concerns in a prompt and fiscally prudent manner. I thank you again for holding this hearing, and I am happy to answer your questions.

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